

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33750**
Registration District No. **4339**
Registrar's No. **4339**

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Research Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **13 days**
(Specify whether years, months or days) **13 days**

3. (a) PRINT FULL NAME **Benjamin Franklin Daniel**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Julia Daniel** 6. (c) Age of husband or wife if alive **62** years
7. Birth date of deceased **Sept. 21 1872**
(Month) (Day) (Year)

8. AGE: Years **71** Months **2** Days **13** If less than one day
hr. min.

9. Birthplace **Caline Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business

12. Name **Jno. W. Daniel**

13. Birthplace **Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Ann Lucas**

15. Birthplace **Ill.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Eli Daniel**

(b) Address **William, Mo.**

17. (a) **Burial** (b) Date thereof **10-12-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Slater, Mo.**

18. (a) Signature of funeral director **Sheil Funeral Home**

(b) Address **K.C. Mo.**

19. (a) **10-12-43** (b) **D. E. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Slater, Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **9**
year **1943** hour minute M.

21. I hereby certify that I attended the deceased from **Sept 27**
1943 to **Oct 9**, 1943
that I last saw him alive on **Oct 8 - 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death

Pulmonary edema

Due to **Acute pulmonary fibrosis - (cardiac failure from chronic myocarditis)**

Due to **Prostatic Surgery - Transurethral resection**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Enlarged Prostatic lobes**

Of operations **Path. Report - Carcinoma of prostate**

Of autopsy **None**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **D. E. Brown** (M. D. or other)

Address **1019 P. Bldg** Date signed **10/12/43**

Dr. R. Lee Hoffman
Prof. Bldg.

He 4022

11 Feb 4

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.